Wisconsin Department of Health Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015841 | A. BUILDING: _____ B. WING _____ | R-C 11/22/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLOUEZ PARKSIDE VILLAGE 2 | 1901 LIBAL STREET GREEN BAY, WI 54301 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {N 000} | Initial Comments<br><br>On 11/21/2023, Surveyors conducted a verification visit for statement of deficiency (SOD) ZH5J12, one (1) complaint investigation and reviewed one (1) self-report. Additional information gathered through 11/22/2023. As a result of the survey all previous deficiencies had been corrected, the complaint was unsubstantiated and there were no findings with the self-report.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 50 | {N 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE